The National Tobacco Control Program: Focusing on Policy to Broaden Impact

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SYNOPSIS

Tobacco use is the single most preventable cause of death and disease in the United States, causing more than 440,000 premature deaths annually. We can dramatically reduce the health and economic burden of tobacco use by employing proven tobacco control and prevention strategies. Policy interventions offer the greatest opportunity to influence decisions regarding tobacco use at the societal level. Tobacco control policy can drive social, environmental, and systems changes, and has a substantially greater impact than interventions that target individuals. A policy approach engages the larger community and empowers it to establish healthy social norms. Health departments, the primary governmental institutions charged with protecting the health of the public, play many different roles in advancing policy. The National Tobacco Control Program funds state health departments to educate the public and decision makers regarding evidence-based policy strategies. This article outlines those strategies, critical success factors, and challenges associated with policy-based interventions.

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Tobacco use in the United States has a tremendous health and economic impact. It is the single most preventable cause of death and disease in the United States, causing more than 440,000 premature deaths annually from 1995 to 1999.1 Smoking causes lung and other cancers, heart disease, and chronic respiratory diseases.² One in every five deaths in this country is attributable to smoking. Smoking among adults has been declining since the mid-1960s, although this decline slowed in the 1990s. Even so, 46.5 million American adults still smoke.3 In 1998, smoking-attributable, direct medical care costs were more than \$75.5 billion.1 Although increases in youth smoking that occurred in the 1990s have leveled off, every day more than 5,000 young people try cigarettes for the first time.4 If current tobacco use patterns persist in the United States, an estimated 6.4 million of today's children will eventually die prematurely from a smokingrelated disease.5

Chronic diseases caused by tobacco use constitute a persistent public health problem. Although some gains have been made in addressing this dilemma through individual behavioral change interventions, the major advances in chronic disease prevention and health promotion will come through increasing and widespread use of policy and environmental change interventions.⁶ Policy is purposeful action by an organization or institution to address an identified problem or issue through executive, legislative, or administrative means. It can be either voluntary or legally binding. Policy can include laws, regulations, codes, rules, standards, administrative orders, guidelines, mandates, resolutions, and other means of exercising both formal and informal authority. Policy can directly affect the economic, social, or physical environment of larger groups of individuals. While policy is often thought to be directed at the national, regional, state, or local levels, it also exists at the private level, with an individual or group of individuals deciding how to solve a problem that affects them in their business, workplace, school, home, or car.7 Policy interventions offer one of the greatest opportunities to influence decisions regarding tobacco use at the societal level.^{8,9} As noted in a 1988 Institute of Medicine report, "... Policy development is a core function of public health. . . . "10 Policy interventions may have a direct effect on tobacco-related morbidity and mortality, but they often achieve their results through intermediate outcomes such as strengthening motivation to quit, reducing impediments to quitting, creating nonsmoking norms, and reducing stimuli to smoke.8

NATIONAL TOBACCO CONTROL PROGRAM

The Centers for Disease Control and Prevention's (CDC's) Office on Smoking and Health (OSH) is the Department of Health and Human Services' (DHHS') lead office for all policy and programmatic issues related to tobacco control and prevention. As the lead federal agency for comprehensive tobacco prevention and control, CDC/OSH develops, conducts, and supports strategic efforts to protect the public's health from the harmful effects of tobacco use. OSH leads and coordinates strategic efforts to prevent initiation among youth and young adults; eliminate exposure to secondhand smoke; identify and eliminate disparities in tobacco use among population groups; promote cessation among adults and youth; conduct tobacco product research and information dissemination; and promote comprehensive global tobacco-use prevention and control.11

State health departments, the primary governmental institutions charged with protecting the health of the public, are CDC's primary constituents. According to *Policy and Environmental Change: New Directions for Public Health*, a report issued by the Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPHE) and the CDC, ". . . Health departments can play many different roles in advancing policy and environmental change interventions, including providing information, funding interventions, coordinating team efforts, educating the public, and/or advocating for specific policy and environmental change strategies. . . ."6

OSH provides state health departments with funds and technical assistance to establish core tobacco-use prevention and control programs.^{8,12} The CDC supports all 50 states, the District of Columbia, seven U.S. territories, and 11 national organizations as part of the National Tobacco Control Program (NTCP). Federal funding for the NTCP, administered through CDC, is intended to provide a stable foundation upon which state health departments can build an infrastructure to support comprehensive tobacco control activities.¹¹

NTCP framework

CDC has synthesized an evidence-based comprehensive framework for statewide programs to reduce to-bacco use. The conceptual framework integrates four program goals with four program components. The goals are achieved through strategies within these four components. The program goals for reducing tobacco use statewide are to:

prevent initiation of tobacco use among young people,

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- eliminate exposure to secondhand smoke,
- promote quitting among adults and young people, and
- identify and eliminate disparities among population groups.

The program components include four populationbased approaches.¹² Community interventions are programmatic interventions to influence societal organizations, systems, and networks that encourage and support individuals to make behavioral changes consistent with tobacco-free norms. Counter-marketing activities are intended to offset tobacco industry influences and to increase pro-health messages throughout a state, region, or community. They include media relations, media advocacy, counter-advertising, reducing tobacco industry sponsorships and promotions, and exposing tobacco industry tactics. Program policy and regulation includes policy analysis and the education of decision makers and the public on the importance and benefit of public health policies such as clean indoor air, excise taxes, product regulation, insurance coverage for tobacco use treatment and cessation programs, and ingredient disclosure. Public policies also include ensuring enforcement of laws and regulations related to youth access to tobacco as well as policies that support clinical treatment of tobacco use. Surveillance and evaluation are, respectively, the regular monitoring of relevant measures over time to inform program and policy direction and interventions and point-in-time assessments to measure the effectiveness of programs, policies, and media efforts.

Major policy areas and approaches

Clean indoor air policy. As noted in the 2000 Report of the Surgeon General, involuntary exposure to second-hand smoke remains a common public health hazard that is entirely preventable. Secondhand smoke is a known human carcinogen, one that is responsible for at least 3,000 lung cancer deaths each year, 3 as well as an estimated 35,000 cardiovascular deaths, the exacerbation of hundreds of thousands of cases of asthma, lower respiratory tract infections, and middle ear infections. 4

Smoke-free environments provide strong reinforcement of nonsmoking as a social norm. The Task Force on Community Preventive Services reviewed a number of studies on smoke-free environments that have been shown to decrease consumption and increase cessation rates. The Task Force strongly recommends smoking bans and restrictions to effectively lower exposure to secondhand smoke. Additionally, the 2000 Surgeon General's report, *Reducing Tobacco Use*, con-

cludes that smoking bans are the most effective means for reducing exposure. But Currently, smoking policies in the worksite protect 69% of Americans. Worksite exposure varies, however, ranging from 48.9% in Nevada to 81.7% in Maryland. The most of the most effective means for reducing the smoking bans are the most effective means for reducing a smoking policies in the worksite protection. Worksite exposure varies, however, ranging from 48.9% in Nevada to 81.7% in Maryland.

Many American homes (61%) are smoke-free. The range is 39.7% in Kentucky and 81.7% in Utah for protection from secondhand smoke in the home through bans on smoking in the home.⁵ The American Nonsmokers' Rights Foundation Local Tobacco Control Ordinance Database indicates that as of January 1, 2003, there were almost 1,540 local smoke-free air ordinances and regulations in the United States.¹⁵

Tobacco use treatment. The Healthy People 2010 goal for adult smoking prevalence is 12% or less by the year 2010.16 Unless smoking prevalence declines at a more rapid rate than observed in the past, this goal will not be met. Tobacco dependence has been defined as a chronic condition¹⁷ or chronic disease.⁸ Still, many of the adverse health effects of tobacco use are reversible by cessation.¹⁷ Treating Tobacco Use and Dependence: A Clinical Practice Guideline, published by the U.S. Public Health Service (PHS), summarizes advances in treating tobacco use and nicotine addiction.¹⁷ The guideline indicates that less intensive interventions, which are as simple as physicians advising their patients to quit smoking, can produce cessation rates of 5% to 10% per year.¹⁷ More intensive interventions, combining behavioral counseling and pharmacological treatment, can produce quit rates of 20% to 25%.8 Recommendations in the PHS Guideline that involve systems and policy changes include reminder procedures and physician reimbursement as important health care system modifications.¹⁷ The PHS clinical guidelines recommend use of the telephone to deliver cessationcounseling services. Thirty-three states currently offer smoking cessation counseling quit lines.¹⁸

The Task Force also strongly recommends reducing patients' out-of-pocket costs for effective cessation treatments in order to increase their use and the number of patients who quit. In 1998, 24 states and the District of Columbia offered some Medicaid coverage for tobacco-dependence treatment; in 2000, nine more began offering some coverage. In 1998 and 2000, only one state, Oregon, offered coverage for all the counseling and pharmacotherapy treatments recommended by the PHS Clinical Practice Guideline.

Access by minors. All states currently have laws that prohibit the sale or distribution of tobacco products to minors.⁸ Enforcement of these laws has been shown to increase compliance and to reduce buy-rates among minors.²⁰ Although the evidence linking reduction of

youth smoking to access restrictions for minors is limited, it does suggest that, in conjunction with community education, such restrictions are an important part of a comprehensive program.⁸

Advertising and promotion. In 2000, the tobacco industry spent \$9.57 billion on advertising. As noted in the 2000 Surgeon General's Report Reducing Tobacco Use, regulation of advertising and promotion, especially that which is directed at young people, is likely to reduce both the prevalence and uptake of smoking. As outlined in the Surgeon General's Report, The Master Settlement Agreement with the tobacco industry includes several restrictions on advertising and promotion. These include prohibition of brand name sponsorship of events with a significant youth audience, a ban on the use of cartoon characters in advertising, and bans on transit and outdoor advertising and on billboards.

Economic approaches. The 2000 Surgeon General's Report concluded that raising tobacco excise taxes is widely regarded as one of the most effective tobacco prevention and control strategies.⁸ Price increases on cigarettes have been shown to promote smoking cessation among adults, to reduce cigarette consumption among continuing smokers, and to prevent initiation among youth. The Guide to Community Preventive Services recommends increasing the unit price of tobacco products as effective in both increasing cessation and preventing youth initiation.⁹

Research indicates that for every 10% increase in price, overall smoking rates would decrease by 3% to 5%. Data indicate that youth and young adults are even more price sensitive than adults, and that a 10% increase in price would result in a 7% decrease in youth smoking prevalence. Studies of smokeless to-bacco products suggest that increasing their prices would also reduce the prevalence of use. Because increased excise taxes raise the price of cigarettes, they provide a cost-effective, short-term strategy to reduce tobacco use among both adults and young people.

Mass media and counter-advertising. Mass media campaigns, combined with other interventions, were also determined to be effective in reducing the prevalence of tobacco use among adolescents and in promoting adult cessation. The mass media provide an important means to educate and inform the public, and through public response, policy makers. The media play an important role in influencing the smoking behavior of individuals and the actions of policymakers in both the public and private sector. The Task Force strongly recommends mass media campaigns featur-

ing long-term, high-intensity counter-advertising as an effective strategy to reduce adult prevalence by increasing cessation.⁹

Synergistic effects. The most significant and sustained declines in population levels of tobacco consumption have been observed in states where changes in the social environments—rather than enhanced clinical services—have been the focus of the programs.⁸ In particular, these changes include increased tobacco taxes, sustained counter-advertising, and expanded clean indoor air restrictions. Reducing the prevalence of tobacco use requires efforts to change social norms regarding the acceptability of tobacco use.⁸

The 2000 Surgeon General's Report notes that "... reducing the broad cultural acceptability of to-bacco use necessitates changing many facets of the social environment . . ." and that "... these individual components must work together to produce the synergistic effects of a comprehensive program. . . ." For example, school-based smoking prevention programs that identify social influences to smoke and teach skills to resist those influences have accomplished reductions in adolescent smoking prevalence. Community-wide programs that involve parents, mass media, community organizations, and other elements of an adolescent's social environment enhance the strength of this effect.²⁴

The Oregon tobacco control program included an implementation of the CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* in 30% of their schools. ²⁵ This demonstration found that a comprehensive school-based tobacco prevention program that includes tobacco-free school policies and community involvement as one component of a statewide tobacco program may contribute to reductions in current smoking among eighth-graders. The Oregon program also found significantly greater declines in smoking prevalence in the schools that rated high or medium on implementation criteria compared with schools that rated low. ²⁶

Importance of a comprehensive approach

Each of the approaches described in the previous sections contributes to a comprehensive tobacco control program. Although federal funds are adequate to establish a minimal infrastructure, they are not sufficient to implement a fully comprehensive tobacco control program. Nevertheless, aggressive and comprehensive tobacco control programs in a number of states with well funded programs from dedicated excise tax dollars have produced substantial declines in cigarette use.

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In California, where a tobacco control program has been funded by excise tax revenues since 1989, tobacco rates have declined two or three times faster than in the rest of the country. California is the first state to demonstrate a reduction in tobacco-related deaths. The incidence of lung cancer in California has declined significantly faster than in other parts of the United States, and California has also seen dramatic declines in cardiovascular disease death rates. 27,28

During the 1990s, when smoking rates among youth in the United States were consistently increasing, rates in Massachusetts and California appear to have risen more slowly ²² and even declined among seventh- and eighth-graders in Massachusetts. ²³ In 1992, Massachusetts initiated a comprehensive statewide tobacco control program. From 1992 through 2002, per-capita consumption in Massachusetts declined by 40%; and from 1993 through 2002, smoking prevalence among adults declined from 23.1% to 18.4% (Centers for Disease Control and Prevention, unpublished data, 2003).

With the influx of revenues resulting from state settlements with the tobacco industry and increases in state tobacco excise taxes, additional states such as Minnesota, Florida, Arizona, and Oregon were also able to implement comprehensive tobacco control programs. The 2000 Surgeon General's Report *Reducing Tobacco Use* provides several examples of substantial declines in cigarette use among states with comprehensive programs funded by dedicated excise tax revenue.⁸

With the support of a dedicated excise tax, Arizona was able to begin funding a comprehensive tobacco control program in 1996. During this time, smoking prevalence declined significantly in women and men, whites and Hispanics, and people with low income and low levels of education. The greatest decrease in smoking prevalence, by age, was among smokers older than 65 years. By income level, the most substantial decline in smoking prevalence was among those with a household income of less than \$10,000 per year. By education level, the greatest reduction in smoking was among persons with an eighth-grade education or less.²⁹

Oregon launched a comprehensive statewide to-bacco control program in 1997 with the support of a dedicated excise tax. From 1996 to 1998, cigarette consumption declined by 11.3% and smoking prevalence by 6.4%.

CHALLENGES AND OPPORTUNITIES

While the implementation of tobacco control programs has resulted in significant reductions in smoking prevalence rates in the United States, many challenges still lie ahead.

Maintaining and sustaining resources for tobacco control

Evidence indicates that the rate of progress toward achieving tobacco use reduction objectives will be related to the level of investment in evidence-based strategies within comprehensive tobacco control programs.^{28,30} In fact, evidence clearly shows that increases in funding for state tobacco control programs reduce tobacco use. As noted in a study published in the Journal of Health Economics, between 1990 and 2000, cigarette sales dropped more than twice as much in states with comprehensive tobacco control programs than in the United States overall.²⁸ Sales dropped an average of 43% in four key states (Arizona, California, Massachusetts, and Oregon) compared with 20% for all states. The more states spend on comprehensive programs, the more efficient they become, and the longer states invest in tobacco control, the larger the impact.28

Unfortunately, recent budget cuts and competing priorities in a number of states have led to substantial cuts in tobacco control program funding. ^{28,31} These reductions, from either excise taxes or settlement funds, will dramatically decrease the extent and intensity to which statewide programs may be implemented.

During the period in which this article was being written, the situation for state tobacco control programs changed dramatically. State budgets were drastically cut because of the poor economy. As of October 2003, 23 states lost substantial funding for comprehensive tobacco control. The impact of this budget crisis resulted in the dismantling of essential countermarketing campaigns, the discontinuation of quit-lines and community programs, and the layoffs of tobacco control program staff members.

The highly successful programs in California, Massachusetts, Oregon, Arizona, and Florida received deep cuts in their funding. Florida cut funding for its program despite reducing smoking rates by 47% among middle school students and 30% among high school students in just three years. California, which has the nation's longest operating tobacco control program, cut its tobacco control budget in half, despite the fact it saved 33,000 lives by reducing heart disease mortality in the first nine years of the program.³² Despite having one of the oldest and most successful tobacco prevention programs, and one which has served as a national model, Massachusetts has seen a 95% cut in funding for their tobacco control program over the past two years.³³

The experience to date has shown us that policy makers appear not to view comprehensive tobacco control programs as a permanent part of the public health infrastructure. Although other public health programs have received severe cuts in these tough budget times, we have not seen their complete elimination. Nor would an immunization coverage rate of only 25% to 30% for our children be tolerated. However, it is apparent that policymakers view tobacco control programs as being optional—even in light of the strong and growing evidence that tobacco control works.

The CDC/OSH, the National Cancer Institute, and the American Legacy Foundation have launched an evaluation effort to monitor the effect of budgets cuts on tobacco control programs. This will enable development of science-based guidance to states facing similar budget cuts, help link specific program reductions with intermediate and long-term changes in outcome measures, and increase understanding of how reducing or eliminating tobacco control programs will affect organizational capacity. Finally, a thorough evaluation of state program reductions will help increase understanding of what happened, why it happened, and which specific tobacco control components or mix of activities are most essential to retain within state programs.

Identifying and eliminating disparities

The prevalence of current smoking varies significantly among racial and ethnic groups. Additionally, there are varying levels of disparities by education, age, socioeconomic status, disability status, geographic location, and sexual orientation relative to tobacco use, its effects, exposure to secondhand smoke, and access to tobacco use treatment.³² When comprehensive programs and policy interventions that are appropriate and effective for each population group are implemented and sustained, the goal of eliminating disparities relative to tobacco use can be attained. It is important to establish a science base that helps to identify disparities, as well as an evidence base of effective programmatic and policy interventions. Toward this end, CDC has dedicated funds as part of the NTCP for a network of national organizations that can plan, initiate, coordinate, and evaluate tobacco use prevention activities to reduce tobacco use in priority populations.⁵

Implementing successful strategies

As results are obtained from these most recently well funded state programs and added to the continuing data from California, Massachusetts, Arizona, Oregon, and Florida, our understanding of the potential effectiveness of the full, multi-component population-based approach to tobacco control will continue to expand. However, the data are already strong enough for the U.S. Surgeon General to conclude that "... we know more than enough to act..." and that if the recommended tobacco control strategies were fully implemented, rates of tobacco use in the United States could be cut in half by the year 2010.8

Successful state experience in effective policy development and implementation has been shown to rest on a strong science base. To translate the science into practice, however, it must be strategically communicated to the public and decision makers. Sustainable policy changes require community involvement and mobilization and meaningful collaborations among a variety of partners and stakeholders. These can be effective only when there has been an accurate assessment of community readiness, a clear plan of action, and realistic expectations.

Without sustained and comprehensive efforts to reduce rates of tobacco use, chronic diseases related to tobacco will continue to increase. Tobacco use continues to be the number-one preventable cause of death in this country. We cannot become complacent and allow other issues to overshadow this critically important public health threat. While we have seen decreases in tobacco use prevalence, these rates could easily be reversed. Lessons from recent public health history—TB and syphilis control, for example—illustrate how disease rates can rebound when our attention, and resources, are distracted from a continuing problem.

We have the ability to dramatically reduce the health and economic burden of tobacco use by employing proven tobacco control and prevention strategies, including the policy strategies discussed in this article. Achieving this goal will require collaboration among state health departments, state decision makers, public health officials, business leaders, and community members.

The authors thank Rosemarie Henson, Director of CDC's Office on Smoking and Health (OSH), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), and all OSH managers for their guidance and support. We would also like to acknowledge OSH's Policy Team for their technical assistance in preparing this paper.

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